This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.coxhealthplans.com or by calling 1-800-205-7665.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$7,150 person/ $14,300 family in-network provider. $14,300 person $28,600 family out-of-network provider Doesn't apply to preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
Is there an out–of–pocket limit on my expenses?	Yes. For InNetwork providers $7,150 person/ $14,300 family. For Out-of-Network providers $20,000 person/ $40,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.coxhealthplans.com or call 1-800-205-7665 for a list of in-network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/visit $0 Mental Health copay/visit	30% coinsurance	Copay covers services billed by the physician for the same date of service.
	Specialist visit	$0 copay/visit	30% coinsurance	Copay covers services billed by the physician for the same date of service.
	Other practitioner office visit	$0 copay/visit for chiropractor	30% for chiropractor	Copay covers services billed by the physician for the same date of service. Limited to 26 visits per calendar year without preauthorization.
	Preventive care/screening/immunization	No Charge	30% coinsurance	No charge only for services recommended by the U.S. Preventive Services Task Force as mandated by PHSA Section 2713
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.coxhealthplans.com.	Generic drugs	$0 prescription retail and $0 mail order	30% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Certain drugs may have a 50% penalty applied without preauthorization.
	Preferred brand drugs	$0 prescription retail and $0 mail order	30% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Certain drugs may have a 50% penalty applied without preauthorization.
	Non-preferred brand drugs	$0 prescription retail and $0 mail order	30% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Certain drugs may have a 50% penalty applied without preauthorization.
	Specialty drugs	0% coinsurance up to $100 max	Not Covered	Covers up to a 30-day supply (retail prescription). Mail order not covered. Certain drugs may have a 50% penalty applied without preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	Certain outpatient procedures and/or therapies may have limitations and have a 50% penalty without required preauthorization.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	Certain outpatient procedures and/or therapies may have limitations and have a 50% penalty without required preauthorization.
If you need immediate medical attention	Emergency room services	$0 copay/visit	$0 copay/visit	----------None----------
	Emergency medical transportation	0% coinsurance	0% coinsurance	----------None----------
	Urgent care	$0 copay/visit	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers.
	Physician/surgeon fee	0% coinsurance	30% coinsurance	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers.

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance.	30% coinsurance.	----------None----------
	Mental/Behavioral health inpatient services	0% coinsurance.	30% coinsurance.	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers.
	Substance use disorder outpatient services	0% coinsurance.	30% coinsurance.	----------None----------
	Substance use disorder inpatient services	0% coinsurance.	30% coinsurance.	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers.
If you are pregnant	Prenatal and postnatal care	0% coinsurance	30% coinsurance	----------None----------
	Delivery and all inpatient services	0% coinsurance	30% coinsurance	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	50% penalty may be applied without preauthorization.
	Rehabilitation services	0% coinsurance	30% coinsurance	Physical Therapy, Occupational Therapy, & Speech Therapy each limited to 60 days per calendar year. Physical/Occupational require authorization for home visits. All Speech Therapy requires authorization. 50% penalty may be applied without the required preauthorization.
	Habilitation services	0% coinsurance	30% coinsurance	Autism (BCBA, BCaBA specialties only) requires preauthorization and is limited to individuals through 18 years of age.
	Skilled nursing care	0% coinsurance	30% coinsurance	50% penalty may be applied without preauthorization.
	Durable medical equipment	0% coinsurance	30% coinsurance	50% penalty may be applied without preauthorization.
	Hospice service	0% coinsurance	30% coinsurance	50% penalty may be applied without preauthorization.

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for eye exam.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (26 visits per calendar year without prior authorization)
- Cosmetic surgery (With prior authorization)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the **plan** at 1-(800) 205-7665. You may also contact your state insurance department, the U.S. Department of Labor at www.dol.gov/, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the insurer at 1-(800) 205-7665. You may also contact your state insurance department at 1-(800) 726-7390.

Additionally, a consumer assistance program can help you file your **appeal**. You may also contact them at 1-(800) 726-7390.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Non-English speaking language assistance services, free of charge, are available to you. Call 1-844-563-0782 (TTY: 1-800-735-2966).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $140**
- **Patient pays $7,400**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$7,200
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$200
Total	**$7,400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $20**
- **Patient pays $5,380**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,300
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$80
Total	**$5,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Design Name **Design_010B**

Description **GROUP_PPO_PARTNERS_AI_NO_RX_DED_MOOP_OV/ER/UC_25% spec drugs**

SBC Document Collection : Design_010B
- PlanID : PSXBP2815C010729081
- EffectiveDateEnd : 12/31/2078
- EffectiveDateStart : 01/01/2015
- PharmacyCode : X0D3TF40pEQ2XX

Plan Name : PlanName_046
- PlanID : PSXBP2688C010654941, PSXBP2789C010697851, PSXBP3853C010793221

CoPays and CoInsurance : CHP252a
- PlanID : PSXBP3853C010793221
- SBCEffectiveDate : 01/01/2016
- SBCTermDate : 12/31/2078